Patient Health History

Name: _____ Date:_____

	Yes	No
Do you currently wear glasses?	☐	☐
Do you currently wear contacts?	☐	☐
Have you had Laser Vision Correction?	☐	☐
Are you interested in Laser Vision Correction?	☐	☐

Approximately how many hours a day do you work on a computer? _____

List any special interests, hobbies or job requirements that may be affecting your vision.

_____ _____ _____

_____ _____ _____

Are you pregnant or nursing? Yes No

Are you experiencing any of the following? *(Please check any that apply)*

Burning Eyes	☐	Eye Strain	☐	Lazy Eye	☐	Red Eyes	☐
Distance Vision Blurred	☐	Eye Surgery	☐	Light Sensitivity	☐	See Spots	☐
Double Vision	☐	Flashing Lights	☐	Loss of Vision	☐	Twitching Eyelids	☐
Dry Eyes	☐	Headaches	☐	Near Vision Blurred	☐	Watering Eyes	☐
Eye Injury	☐	Itching Eyes	☐	Migraine Headaches	☐		

Please check which of the following apply to you or a family member

	Self	Family		Self	Family
Blindness	☐	☐	Cancer	☐	☐
Cataracts	☐	☐	Diabetes	☐	☐
Glaucoma	☐	☐	Hay Fever	☐	☐
Macular Degeneration	☐	☐	Heart Condition	☐	☐
Retinal Detachment	☐	☐	High Blood Pressure	☐	☐
			High Cholesterol	☐	☐
Aids	☐	☐	Migraine Headaches	☐	☐
Allergies	☐	☐	Rheumatoid Arthritis	☐	☐
Anemia	☐	☐	Skin Conditions	☐	☐
Asthma	☐	☐	Thyroid Disease	☐	☐

Please list any medications:

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Please list any medications you are allergic to:

_____ _____ _____

_____ _____ _____